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ANALYSIS OF FIFTEEN MONTHS' ABDOMINAL WORK IN THE GYNÆCEAN HOSPITAL (Philadelphia.)*

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The analysis here given is offered to show the character and frequency of complications in abdominal and pelvic surgery, and not its pathology. For this reason the classification is arbitrary. Most of the cases have been reported in Society transactions, and the specimens exhibited, so that I will make no detailed report of them here. The list includes sixty-four consecutive operations, done within the past fifteen months during my service at the hospital.

None of the operations were done for hysteria, menstrual or hystero-epilepsy; none for pain or subjective symptoms, unless objective lesions were clearly recognized. Some of the cases came into my hands from my dispensary service, while others were referred to me in my private practice by men of

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large experience and good judgment. Many were very ill when I took them in hand. None of the cases were operated upon without fully explaining, so far as it was possible, the general nature of the operation to which they were about to be subjected, its reasons, its advantages, its dangers, with honorable carefulness to friends and patient. Too many cases that go on the operating table are told that nothing short of an operation will cure them, without being told the nature, object, and results of the operation. This has happened many times to both single and married patients. That this should be done can only be explained on the supposition that an explanation will scare away the patient and an operation be lost. Operators so eager for work as this would indicate involve themselves in the extremest contradictions, as the records of one of our societies will show. One operator has cited cases to show that pain was the only reason for operative interference in some of his most successful cases, while anon he urges that it would be better if pain *per se* were never considered a sufficient indication for operation. Such enthusiasm were better directed to neglected cases where grossest lesions are present and the sufferers are dying untouched.

Nearly every case here reported has been in some institution, undergone one of the many so-called conservative forms of treatment, running from simple blisters to the cautery, actual and electrical, while they suffered the tortures of the lost in a fool's paradise. Many had repeated attacks of localized peritonitis, while in nearly all the disease had been of long standing, the suffering being constant and great.

The comparative difficulty of abdominal and of pelvic surgery ought not to pass unnoticed. In its complications and their variety the latter is by far the more trying. In abdominal adhesions an enlarging of the incision will generally offer a commanding point for the difficulty. This is not the case in

pelvic adhesions, where often a conglomerate mass is met, to see which will not benefit in the least, and to handle which is impossible to a greater degree than can be accomplished by two fingers.

I will now notice some of the complications in detail, and also the technique of certain operations: In six cases I have operated for the removal of the appendages owing to fibroid disease of the uterus. The complications here were numerous, involving many of the ordinary forms of ovarian and tubal disease, with common ovarian cyst. The indications were two-fold: primarily for local disease, and secondarily to control advancing fibroid enlargement. The early removal of the appendages in this condition is one of the most successful operations in pelvic surgery. The recurrence of bleeding in these cases is perhaps less than in any other form of disease for which the operation is done, and the relief of suffering is notable.

In the advanced form of uterine myoma hysterectomy is to be considered. The safest and surest method at the present is that which deals extra-peritoneally with the stump. So far as results are concerned this is, by all odds, the ideal method. The reasons for this superiority, briefly stated, are these: The pedicle or stump is absolutely under control, as it undergoes shrinkage; it is entirely outside of the abdominal cavity; it can be treated safely by the dry method, with no possibility of infection, thus minimizing all danger. The causes for mortality in the intra-peritoneal treatment are: the large size of the pedicle; its vascularity; its tendency to shrink, and its liability to slough. The patients thus treated are prone to die of hemorrhage and sepsis. I have had nine consecutive hysterectomies, treated extra-peritoneally, without a death. My only death in hysterectomy was in a case in which there was concurrent cancer of the bowel.

I have had in this series fifteen cases of double pyosalpinx. In all these the adhesions were marked, implicating variously the intestine, bladder, omentum, and the sigmoid cellular tissue. The adhesions vary from dense organization to a friable, cheesy condition, easily broken down. The abscess tracks met in this condition are most various. They are sometimes single, oftener multiple, to as many as three or four. Herein appears the non-scientific character of attempted drainage by the vagina. In no other condition are we so certain of remedying the disease by direct interference and direct drainage. The method *par excellence* is to extirpate the abscess cavity or cavities and thoroughly cleanse and drain the pelvis, with the assurance that in the vast majority of cases recovery is certain. In five cases I met pyosalpinx, thus demonstrating that the double condition is most frequent. It is my practice, in dealing with single pus tubes, to remove both, knowing that in many cases there is specific cause for the disease, which will eventually necessitate a second operation if the present advantage is not seized upon to prevent it. The recognition of pus in the pelvis is not difficult. With a little special training it can be determined generally with sufficient precision to leave no doubt as to the advisability of operation.

There is no treatment for pus but the knife. The earlier the operation is done the better. It is especially to be urged owing to the undoubted tubercular tendency generated in patients so affected. This has long ago been demonstrated by Bernütz and Goupil, and I have repeatedly called attention to it in my own work. I have repeatedly arrested the progress of such disease by operation.

In five cases double hydrosalpinx was met, and in three single hydrosalpinx. The adhesions here were such as have already been referred to above. Broad ligament cyst, ovarian abscess and hematoma were also met as complications of this condition. The number of ovarian cysts was seven, the adhe-

sions involving variously the intestine, omentum and uterus. There was one dermoid cyst. There were two cases of double acute salpingitis, with dense and extensive adhesions. The number of chronic cases of salpingitis was eleven. In these the double-sided lesion by far preponderated, with occlusion of the tubes and dense adhesions.

I twice operated for extra-uterine pregnancy; both times after rupture. In both the disease was bilateral, and in both it was simply suspected, because the lesion was bilateral. In one case there was hydrosalpinx of the opposite side. In the other the extra-uterine pregnancy was probably double; the existence of tubal and ovarian disease predisposes these women to extra-uterine pregnancy. In two of my cases I found a tubal pregnancy on one side and a hydrosalpinx on the other. Bantock found pyosalpinx on one side, and a tubal pregnancy on the other. Edis found a small ovarian cyst, with tubal disease on one side and a tubal pregnancy on the other. Other well-authenticated cases might be quoted. Such cases as these must show the utter uncertainty of positive diagnosis. There is but one treatment, American or English; this is early and absolute removal of the murderous mass.

Under what may be classed as miscellaneous operations there was one supra-vaginal hysterectomy, complicated with double hydrosalpinx, cyst of the left broad ligament, and cystic ovaries. There were no adhesions. There was one perirenal cyst, one parovarian cyst, one ventral hernia, a bicornuate uterus from which the appendages were removed, one exploratory incision, with a case of double simple ovarian cyst with dense adhesions. Blood cysts are very common, as also effusion of blood into the tubes. These are not ectopic pregnancies, notwithstanding the fact that macroscopically they greatly resemble it.

More than sixty per cent. of the cases were drained. The after-treatment was simple, and wholly in the hands of myself

and a young, specially trained nurse. Anodynes were administered in three cases only, where the morphine-habit already existed, contracted in a general hospital while suffering for unrecognized trouble. All of the cases recovered without sequelæ; no sinuses formed, and no ligatures have ever been discharged, notwithstanding they were applied to unhealthy structures. Many greatly emaciated and greatly exhausted patients speedily recovered good health.

Such results can only be attained by the utmost painstaking and care. The work is commonly difficult, always liable to be so; and only perfection of methods, exact detail, entire simplicity, and constant care can yield success. This success is often the greatest and only adequate recompense for a work which, in the extent and magnitude of its complications surpasses all other surgery, and which, the better it is understood, the more it will be relegated into the hands of the few, out of the hands of the many, for its perfect accomplishment.

A. *Removal of both appendages for fibroid uterus*, complicated by—

a. Dense universal adhesions and retroversion (pelvis-bound)	1
b. Dense universal adhesions and retroversion (right hydrosalpinx, left acute salpingitis, and double ovarian cystoma)	1
c. Dense universal adhesions and retroversion (double chronic salpingitis and left ovarian cyst)	1
d. Dense universal adhesions and double chronic salpingitis	1
e. Chronic salpingitis, cyst of left ovary, blood cyst of right ovary	1
f. Double ovarian cysts (large)	1
	6

B. *Double pyosalpinx*, complicated by—

a. General friable adhesions	6
b. General healthy adhesions	1
c. General healthy adhesions (especially to sigmoid), cellular tissue abscesses both sides, general peritonitis	1
d. General peritonitis	1
e. Ovarian abscess one side, dense bowel adhesions	1
f. Ovarian abscess one side, dense bowel adhesions (large peritoneal cyst)	1

g. Ovarian abscess one side, dense bowel adhesions (necrotic patches on tubes, purulent peritonitis) 1
h. Ovarian abscess one side, dense bowel adhesions (patches on bowel necrotic through to mucous coat) 1
j. Ovarian abscess one side, dense retro-peritoneal cyst 1
k. Blood cyst one side, cheesy, friable adhesions—omentum, bladder, uterus, appendages and intestine fused into one mass 1

15

C. *Pyosalpinx. one side* (one side removed). complicated by—
a. General firm adhesions, involving tube, omentum, and intestine, post puerperal 1
b. General firm adhesions, multiple cellular tissue abscesses, peritonitis (other side removed fifteen months previous for pyosalpinx) 1
Both sides removed—
c. Ovarion cyst same side, broad ligament cyst opposite side. 1
d. Ovarian cyst same side, broad ligament cyst same side, occluded adherent tube opposite side 1
e. Ovarian and multiple cellular tissue abscesses same side, salpingitis and adherent ovary opposite side, peritonitis . . 1

5

D. *Double hydrosalpinx* complicated by—
a. Dense bowel adhesions 2
b. Dense bowel adhesions and double multilocular ovarian cysts 1
c. Dense bowel adhesions and ovarian abscess, one side . . . 1
d. Dense bowel adhesions and broad ligament cyst, one side.. 1

5

E. *Hydrosalpinx, one side*, complicated by—
a. Firm adhesions 1
b. Firm adhesions and adherent ovary same side, blood cyst of other ovary 1
c. Firm adhesions and adherent ovary same side, cyst of other ovary, and soft myoma of uterus, pregnancy suspected . . 1

3

F. *Ovarian cyst, one side*, simple. 2
Complicated by—
a. Salpingitis same side, firm, healthy adhesions to uterus, omentum and intestine 1

b. Adherent occluded tube and ovary opposite side (both sides removed). 1
c. (Blood cyst.) Both tubes tuberculous and adherent (both sides removed) 1
d. (Large multilocular cyst.) Rupture (post-puerperal), peritonitis 1
e. (Dermoid cyst.) Other ovary cirrhotic, general adhesions. 1
7

G. *Double acute salpingitis*, complicated by—
a. Dense healthy adhesions, retroflexed adherent uterus, cyst of one ovary 1
b. Dense heavy adhesions, retroflexed adherent uterus, cystic ovaries, pelvic organs, omentum and intestine matted together 1
2

H. *Chronic salpingitis, tubes occluded, dense adhesions*—
Condition on one side only 1
Condition on both sides 5
Complicated by—
a. Retroflexed adherent uterus 1
b. Retroflexed adherent uterus and cystic and cirrhotic ovaries 2
c. Cystic and disintegrated ovaries 2
11

I. *Ectopic pregnancy*, complicated by—
a. Rupture and hydrosalpinx of opposite tube 1
b. (Probably double) rupture of right tube, contents discharged in abdomen; left tube distended to size of sausage, with clot protruding from pavilion; placenta and membranes near cornual end 1
2

Miscellaneous—
Supra vaginal hysterectomy (fibroid uterus, double hydrosalpinx, cyst of left broad ligament, cystic ovaries, no adhesions 1
Parovian cyst, one side 1
Peri-renal cyst, retroperitoneal 1
Ventral hernia 1
Bi-cornuate uterus, rudimentary appendages, adhesions . . . 1
Exploratory 2
Double simple cysts of the ovaries, firm adhesions 1

DISCUSSION.

Dr. William Goodell wished to congratulate Dr. Price on his admirable success, and also to endorse his statement with reference to extra-uterine fœtation—that is to say that salpingitis often exists on the opposite side. In two cases successfully operated on by himself this was found to be the case. In the third case the unimplicated tube and ovary were sound. He also confirmed his remarks in reference to the success following removal of the ovaries for fibroid tumor. It is remarkable what power this has in arresting the growth of the tumor and in checking hemorrhage. A gentleman here present once sent a patient to Dr. Goodell from Missouri, with a fibroid weighing at least fifteen pounds. He removed the ovaries, and there has since been a great diminution in the size of the tumor. He is somewhat at issue with the reader of the paper in regard to the treatment of the pedicle of fibroid tumors. If it is a supra-vaginal hysterectomy he treats the pedicle by the extra-peritoneal method; but if it is a simple hysterectomy, viz: the removal of a pedunculated fibroid, he does not do so. In the last two years he has treated six or seven cases by dropping the pedicle, with success in every case. One tumor weighed over fifty pounds; another over forty pounds, and a third over thirty pounds. The pedicles were as large as the wrist. Dr. Goodell transfixes and ligates provisionally, then removes the tumor and scoops out the pedicle so as to make it funnel-shaped He next unties the ligature, winds its ends around two forceps handles, and tightens it with all his strength. Then he stitches together the edges of the pedicle. The cases all recover without delay, for the process of recovery is simpler than when the pedicle is treated extra-peritoneally.

Dr. E. E. Montgomery regretted that he did not hear all of the paper, but he must endorse what the author says in regard to the removal of pus in the pelvis. In a number of cases he has tapped and drained by the vagina, but several of them have subsequently required operative interference after the drainage had been maintained some time, and the exudation had changed from a serous to a purulent one. There was considerable difficulty in removing the mass—possibly more than would have been encountered if the operation had been performed primarily. A case recently operated upon was that of a colored woman who had been in the hospital about two weeks with pelvic exudation. This was opened *per vaginam*, and half a pint of serous exudation escaped. A drainage-tube was introduced, and for a few days there was improvement. Later the temperature rose, the discharge became purulent, and

night-sweats supervened. The sac was removed by laparotomy. It was found adherent to the intestine to such an extent that in separating it the bowel was torn. This was at once closed. The opening in the vagina was so large that for several days the fluid used in irrigating passed into the vagina. The subsequent progress of the case has been all that could be desired. This case illustrates the importance of abdominal incision rather than trusting to vaginal drainage.

Dr. Barton C. Hirst desired to record a recent experience, which might modify Dr. Price's edict that operations should not be done for pain alone. Ten days ago he operated on a lady on whom oöphorectomy had been performed some time ago. Since the first operation there had been pain increasing in severity. At the time of operation he was unable to establish any objective sign of trouble. In the original operation one-third of the ovary had been left, and around it were four tight ligatures. After removing the remaining portion of ovary and the ligatures, the woman was entirely free from pain.

Dr. S. Weir Mitchell protested against surgical interference. In the last fifteen years he had seen over twenty cases where the ovaries had been condemned and a surgical operation decided upon, and yet these cases got entirely well without surgical interference. Putting aside a great many of these positive lesions described by Dr. Price, he cannot help thinking that there have been a good many ovaries taken out that should have stayed where Nature put them. He mentioned one illustrative case. Some years ago Marion Sims, of New York, invited him to see in consultation a girl aged seventeen years. Dr. Sims thought that both ovaries were enlarged, and one adherent. She suffered greatly at the menstrual periods, so much so that at times she was nearly insane. After trying a great variety of treatment he had determined that the ovaries should be removed. After going over her case carefully, Dr. M. requested that he be allowed to treat the case for a short time. In three months he had the pleasure of returning her to Dr. Sims perfectly well. She has since married, and has three children. This case is mentioned because the authority for the removal of the ovary was such as everybody respected.

Dr. Price replying, said he was scarcely familiar with the class of cases of hysterectomy to which Dr. Goodell referred. The speaker alluded to large, œdematous, rapidly growing myomas, and to cystic degeneration in large fibromas. The speaker thought that he was right, and that Dr. Mitchell also was right. He agrees with him in everything he said. He had himself never been guilty more than once of removing the ovaries for subjective symptoms. He operates for disease. In Dr. Hirst's case there was an offending organ. This was not a case of pain in a healthy organ.

The great question involved is whether or not the permanent result is satisfactory in hysterical women, referred to by Dr. Mitchell. In the cases reported in the paper read it is fair to say that the operations have been done to save life. Many of the patients had suffered from one to fifteen years. In bleeding fibroids Dr. Price's experience has been that we cure both the hemorrhage and the pain. The operation in hysterical women is a failure. This is almost universally acknowledged. No matter what the character of the suffering may be, the removal of healthy ovaries and tubes in no way benefits these women, except temporarily. Such procedures throw discredit on all pelvic operations, particularly in the class under discussion on which we are called upon to operate to save life.

Another point to which he referred, viz: occasional deaths from opium. Frequently he has taken from patients from one to three drachms of morphia. A recent patient insisted on keeping her pocketbook, from which he took three drachms of morphia. She also had morphia concealed in the corner of the handkerchief she carried to the operating table, and notwithstanding every precaution, she had an overdose of morphia a few hours after the operation.

Dr. Mitchell agreed with Dr. Price in regard to this operation in hysterical women. Many who had both ovaries removed and were none the better for it, seemed to constitute the most irremedial of all the cases of hysteria. There is one condition which makes it justifiable to operate on healthy ovaries. That is where a woman, past the age of probable marriage, is insane only at the menstrual period. In two such cases removal of the ovaries was done at his request by Dr. Goodell. One was a case of homicidal mania at the menstrual periods, and the other case was one in which were developed extraordinary sexual appetites in a woman at other times modest. In both of these cases the recovery was absolute.